DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185464	A. BUILDING _____ B. WING _____	07/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MEADOWS HEALTH CARE CENTER 1	310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted 06/29 - 07/01/2010. A Life Safety Code survey was conducted on 07/08/10. Deficiencies were cited with the highest scope and severity of an "E" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition. Abbreviated surveys were conducted during the standard health survey from 06/29-07/01/2010. KY14946 was found to be Unsubstantiated; KY14793, KY14769, KY14420, KY14309, KY14410, KY14739 and KY14652 were found to be Substantiated.	F 000	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion set forth in the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law.	
F 224 SS=E	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to implement policies and procedures to investigate misappropriation of funds for two (2) of nineteen (19) sampled residents (#14 and #19). The Findings include: Review of the facility's Abuse Policy issued on 03/09 and re-issued on 06/10 revealed that a full investigation will always occur: Action taken will	F 224	F 224- Mistreatment/neglect/ misappropriation 1. Resident # 14 was discharged on 4/9/2010. Missing article reports were reviewed and no other reports were filed for resident # 14. Missing article reports were reviewed for resident #19 and no other reports of missing money were noted. The outcome of both identified investigations reveal both resident #9 and #19 had their concerns resolved. 2. All residents have the potential to be effected by deficiencies cited in F-224. Policies and procedures were reviewed and updated by administrator and DON to ensure complete investigation. All missing article forms were reviewed by administrator and director of nursing to ensure in compliance with policy and procedure.	7/23/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Annette Ann Bays | Administrator | 07/26/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 224	Continued From page 1 be based on the allegation. Employees will be suspended pending investigation if the allegation is for abuse/neglect. If the alleged perpetrator is a visitor or family member, visitation will be restricted or prohibited depending on the allegation. Documentation of ALL steps taken and outcomes will be recorded, dated and signed by those staff assisting with the investigation. 1. A review of the record for resident #14 revealed an admission date of 03/25/10 with the resident being discharged home on 04/09/10. Resident #14 had a diagnosis of Right total knee replacement. The Minimum Data Set (MDS) Assessment completed on 03/30/10 revealed a cognition of zero (0) (independent with decision making). An interview with Resident #14, on 07/01/10 at 2:30pm, revealed on 04/01/10 it was reported to administration that the resident was missing $20 from a locked drawer. The resident stated that two Certified Nursing Assistants (CNA) had gone through his/her drawers the previous day to look for a pair of missing socks. The resident stated he/she had kept the drawer locked at all times and kept the keys rolled in a sock in a different drawer. Resident #14 believed one of the CNA's had came back in the room while the resident was out to therapy and took the $20. The resident was adamant that the drawer was kept locked at all times because the resident had a cell phone and lap top, as well as a $20 dollar bill and some singles for the snack machine. An interview with CNA #11 on 07/01/10 at 2:45pm revealed information regarding Resident #14's missing money, as stated per the resident, involved her and another CNA going into the	F 224	continued from page 2 3. Missing article form implemented to ensure thorough investigation completed, including staff interviews. Staff including all managers and supervisors in-serviced on the 8th, 9th, and 22nd of July, 2010 on the new missing article form including changes to interview section. Social Services Director to update Department heads and managers of missing articles in daily morning meeting. 4. Administrator/DON will review all missing article forms to ensure all steps have been taken and outcomes are recorded, dated and signed by staff assisting with the investigation. Missing article reports will be reviewed by QA committee. 5. Completion date: July 23, 2010.	7/23/2010

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F 224	Continued From page 2 resident's room and looking for some missing socks; however, according to CNA #11 the resident was in the room during the search. CNA#11 stated that the drawer was locked and the resident said they would look in there later for the missing socks. CNA #11 stated she did not know where the resident kept the key to the locked drawer, and did not take any money from Resident #14. CNA #11 stated she came in the next day to work and the Director of Nursing ask her about the missing money and asked for a written statement of what occurred, of which the CNA compiled. CNA #11 stated she was trained on types of abuse during orientation. An Interview with Licensed Practical Nurse (LPN) #8 on 07/01/10 at 3:00pm revealed he had worked there since September 2009. LPN #8 stated he was the person on duty when the complaint was made and he filled out the complaint. The LPN stated that the resident was not using a locked drawer, and that the resident had the purse, checkbook, laptop and cell phone on top of the table. The LPN also stated the resident did not have the key on their wrist that it was kept on top of the table. The LPN stated he never observed the resident lock the drawer. LPN #8 stated when he made the report he had also looked for the money, and the resident was in the room when he searched. An Interview with the Director of Nursing (DON) on 07/01/10 at 3:45pm revealed he had interviewed both CNA's involved in the missing money for Resident #14. The DON stated he had both CNA's write statements of what occurred with Resident #14 before starting back to work. The DON stated he did not interview any other staff because he felt they were the only two	F 224		

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F 224	Continued From page 3 involved. He stated he did talk to LPN #8 but did not write it down because he considered the written investigation his report. The DON was informed of the discrepancies in the interviews with LPN #8, CNA #11 and the resident. The Surveyor was unable to contact the other CNA involved, as she no longer worked for the facility and did not answer phone calls. 2. Interview with Resident #19 on 06/30/10 at 9:35am revealed ten dollars was missing from a billfold that was located in a purse. Resident #19 further stated that he/she was sleeping when the incident occurred. Interview on 07/01/10 at 2:52pm revealed that Resident #19 was asleep in his/her room and that it was another set of ten (10) dollars that was missing. Interview with Licensed Practical Nurse (LPN) #6 on 07/01/10 at 2:45pm revealed that Resident #19 told her that ten (10) dollars was missing and then changed his/her story to ten one-dollar bills was missing. LPN #6 stated that Resident #19's story fluctuated. LPN #6 went with Resident #19 to assess his/her room. LPN #6 stated that she found a total of seven dollars and the resident stated that five (5) dollars were in his/her drawer. Resident #19 would not open the drawer for LPN #6 to assess findings. Interview with LPN #6 on 07/01/10 at 3:00pm revealed that she did not interview CNA's on the unit that day. LPN #6 only did the report provided by the facility. Interview with Director of Nursing (DON) on 07/01/10 at 4:59pm revealed that Resident #19 first stated that he/she was missing seven (7) dollars, and then changed the story to ten (10) dollars. The DON further stated that he did not	F 224		

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F 224	Continued From page 4 interview CNA's on the unit the day the incident occurred. Interview with the Administrator on 07/01/10 at 4:59pm revealed there were no interviews on the nursing report of staff working the shift the day the incident occurred. He further stated they did talk to family and nurses about the incident.	F 224		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	F 225- investigation/report allegations/individuals. 1. Abuse registry checks were completed on July 5th on employee #4 including Missouri and Oklahoma. No residents were identified to be affected. 2. All residents have the potential to be affected 3. All employee files were audited to ensure abuse registry checks were completed in states known for former health care employment. Policy and procedure for screening potential employees was reviewed and updated by administrator and DON. All staff responsible for abuse registry checks were in-serviced on updated policy on screening potential employees. HR director to utilize audit tool developed to ensure abuse registry checks completed on all new hires.	7/23/2010

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F 225	Continued From page 5 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure potential employees were free of abuse findings for one (1) of nine (9) employee records reviewed (#14). Employee #14 was hired by the facility but abuse registries for Missouri and Oklahoma were not reviewed. The findings include: Review of the facility abuse policy, dated March 2009, and re-issued June 2010 revealed potential employees would be screened through the nurse aide abuse registry prior to employment. Review of the personnel file for Employee #14 revealed the employee had lived/worked in Missouri and Oklahoma prior to employment at the facility. There was no evidence provided by the facility to show verification of the employee's abuse findings. Interview with the Staffing Coordinator on 07/01/10 at 3:15pm revealed she completed the abuse registry checks for nursing employees. She stated the facility did not contact any state other than Kentucky for abuse registry information	F 225	Continued from page 5. 4. Administrator/DON to review all audits completed by HR Director to ensure abuse registry checks were completed. 5. Completion date: July 23, 2010.	7/23/2010

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F 225	Continued From page 6 on potential employees. She stated she did not know it was required. Interview with the Director of Nursing on 07/01/10 at 2:40pm revealed the facility only checked the abuse registry in Kentucky even though potential employees may have lived/worked in other states.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to implement their abuse policies to ensure potential employees were free from abuse findings for one (1) of nine (9) sampled employees (#14). The employee had lived/worked in Missouri and Oklahoma and the facility's policy for verifying abuse findings prior to employment was not implemented. The findings include: Review of the facility's abuse policy, dated March 2009 and re-issued June 2010, revealed potential employees would be screened through the nurse aide abuse registry prior to employment. Review of the personnel record for Employee #14 revealed the employee had lived/worked in Missouri and Oklahoma prior to employment at the facility. The facility was not able to provide evidence of implementing their abuse policy and	F 226	F 226- Develop/implement abuse/ neglect, ect . 1. Abuse registry checks were completed July 5, 2010 on employee #4 including Missouri and Oklahoma. No residents were identified to be affected. 2. All residents have the potential to be affected. 3. All employee files were audited to ensure abuse registry checks were completed in states known for former health care employment. Policy and procedure for screening potential employees was reviewed and updated by administrator and DON. All staff responsible for abuse registry checks were in-serviced on updated policy on screening potential employees. HR director to utilize audit tool developed to ensure abuse registry checks completed on all new hires.	7/23/2010

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F 226	Continued From page 7 verifying nurse aide abuse registry findings for these states. Interview with the Staffing Coordinator on 07/01/10 at 3:15pm revealed she was responsible for verifying findings from the nurse aide abuse registry. She stated she was not aware that other states where potential employees lived/worked were also to be verified. Interview with the Director of Nursing on 07/01/10 at 2:40pm revealed the facility only checked the Kentucky abuse registry for potential employees.	F 226	continued from page 7 4. Administrator/DON to review all audits completed by HR Director to ensure abuse registry checks were completed. 5. Completion date: July 23, 2010.	7/23/2010
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, and interview it was determined the facility failed to provide services necessary to maintain a sanitary, comfortable, and orderly interior. The facility did not ensure five (5) wheelchairs with arm rests that were ripped and torn, causing a potential for injury to the residents, was repaired. In addition, a torn floor mat, and six (6) toilets that were not properly affixed to the floor were not repaired. Observation on 06/29/10 between 8:30am and 9:30am during the initial tour revealed five (5) residents with wheelchairs that had arm rests that were torn and in disrepair causing sharp edges that could cause harm to residents. Room 36, bed 1, had floor mats on both sides of the bed	F 253	F 253 Housekeeping & maintenance services 1. The (5) identified wheelchairs were repaired or replaced by July 5, 2010, floor mat was replaced July 1, 2010 and all (6) toilets were repaired by July 6, 2010. 2. All residents have the potential to be affected. All resident wheelchairs, toilets, and floor mats were inspected by staff to ensure they were sanitary, orderly, and comfortable. 3. Staff was in-serviced on July 8th, 9th, and 22nd, 2010 on procedures to notify maintenance of equipment in need of repair including wheelchairs, toilets, and floor mats. Additional supplies for wheelchairs ordered including replacement wheelchairs that could not be repaired.	

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F 253	Continued From page 8 that had mulliple tears and holes exposing some of the foam inside the mats. Observation on 07/01/10 at 10:30am while on environmental tour revealed the toilets in room numbers 2, 4, 8, 9, 16, and 20 were wobbly when manipulated and not properly affixed to the floor. The toilet in room 2 was turned at an angle. The toilets that were not properly secured to the floor had reddish, brown residue around the base of the toilets. An interview with the Maintenance Director on 07/01/10 at 8:55am revealed there was a maintenance log kept at each nurses' station that staff were supposed to use to write down any maintenance issues with residents' equipment. The maintenance staff checked the log six to seven times a day and fixed the problems the same day unless there was a part that needed to be ordered. He went on to say that maintenance depended on the staff to report arm rest problems and equipment problems. An interview with Housekeeper #1 on 07/01/10 at 10:30am revealed she had worked at the facility for twelve years. She stated that she wrote maintenance concerns on the board at the nurses' stations, and she would report the concerns to her supervisor. She stated she did not usually find the toilets loose, but did clean around the toilets. She stated the reddish brown residue is rust spots around the toilet because water leaked out. She stated she did clean around the base of the toilet; however, the rust spots kept coming back, because the toilet leaked. She then stated it had been reported several times but it did not get repaired.	F 253	continued from page 8 4. Weekly audits to be completed by administrative staff to include- wheelchairs, floor mats, toilets, and other areas. Audits will be completed by administrative staff and reviewed by administrator weekly. QA committee to review audits monthly. 5. Completion date: July 23, 2010	7/23/2010

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F 253	Continued From page 9 Interview with Certified Nursing Assistant (CNA) #8 on 07/01/10 at 10:50am revealed she had worked at the facility for four years. She stated she did know to write things on the maintenance log that needed repaired. She stated she had not written anything down because she had not noticed the tears in the wheelchair arms, or any loose toilets. She stated she did know it was important to report maintenance issues with resident equipment because torn arm rests could cause skin tears and wobbly toilets could harm the resident.	F 253		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to complete a significant change Minimum Data Set (MDS) assessment for two (2) of nineteen (19) sampled residents. Both Resident #5 and #8 had a decline in more than two areas of the MDS that	F 274	F 274 Comprehensive assess after significant change 1. Residents #5 & #8 were reviewed to determine if significant change Minimum data Set warranted. No significant change Minimum Data Set warranted for either resident at this time. 2. All current residents have the potential to be effected. All residents were reviewed to determine if significant change Minimum Data Set warranted. 3. MDS Coordinator and MDS nurse were in-service on significant change Minimum Data Set guidelines. All residents RUG analysis reports are to be reviewed with completion of Minimum Data Set. Residents to be reviewed in weekly Standards of Care meeting to determine if significant change Minimum Data Set warranted.	7/23/2010